Skagit Valley Hospital Policy/Procedure

Financial Assistance/Sliding Fee Scale Policy

Patient Accounts 14600 (Rev: 5)Official

Policy

Skagit Valley Hospital is committed to the provision of health care services to all persons in need of medically necessary care regardless of their ability to pay. Financial Assistance/Sliding Fee Scale will be granted to all persons regardless of race, color, sex, religion, age, or national origin. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of Financial Assistance/Sliding Fee Scale, consistent with the requirements of the Washington Administrative Code (WAC), Chapter 246-453, are established. This criteria will assist staff in making consistent and objective decisions regarding the eligibility for Financial Assistance/Sliding Fee Scale while ensuring the maintenance of a sound financial base. All Financial Assistance/Sliding Fee Scale write offs will be approved by the Business Office Director and/or Business Office Supervisor.

Communications to the Public

Hospital's Financial Assistance/Sliding Fee Scale policy shall be made publicly available through the following elements:

1. A notice advising patients that the hospital provides financial assistance and charity care shall be posted in key public areas of the hospital, including Admissions, the Emergency Department, Billing and Financial Services.
2. Written notice of the availability of the Financial Assistance/Sliding Fee Scale will be made available to all patients. This is done at the time that the hospital requests information pertaining to third party coverage. This written information shall also be verbally explained at this time. If for some reason, for example in an emergency situation, the patient is not notified of the existence of the Financial Assistance/Sliding Fee Scale policy before receiving treatment, he/she shall be notified as soon as possible thereafter.
3. Written information about the hospital's Financial Assistance/Sliding Fee Scale policy shall be made available to any person who requests the information.
4. The hospital shall train front-line staff to answer Financial Assistance/Sliding Fee Scale questions effectively or direct such inquiries to the appropriate department in a timely manner.

Eligibility Criteria

All charges not covered by a third party payment source or unpaid patient balances shall be considered for Financial Assistance/Sliding Fee Scale write off. The guidelines used as criteria will include but not be limited to the following:

1. Persons eligible for Financial Assistance/Sliding Fee Scale will be comprised of those deemed to have undue financial hardships, considering income, resources, and obligations as determined by the hospital, that make them unable to pay for all or a portion of their medical care. Such consideration will include a review of gross income as calculated for the twelve (12) month period prior to the date of service, family size, and net worth including short and long term debts and liabilities, and other pertinent factors peculiar to each financial assistance request. If income at time of application is verified to be lower than at time of service, the lesser of the two shall be used for determination.
2. The full amount of current hospital charges will be determined to be Financial Assistance/Sliding Fee Scale for any patient whose gross family income is at or below 100% of the current federal poverty guidelines.
3. The following sliding fee schedule shall be used to determine the patient responsibility amount for patients with income levels 100% and 400% of the current federal poverty level. Note: This percentage is calculated as "1 minus the cost-to-charge ratio" using the prior year's

ratio of costs to charges, such as the one calculated from fiscal information filed with the Washington State Department of Health. A copy of sliding fee scale available in the Business Office.

- The responsible party's financial obligation which remains after the application of the sliding fee schedule may be payable in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the hospital and the responsible party.

4. Applicants residing in a nursing home, long term care facility, or custodial care facility with a disposable income of less than $150 per month may qualify for Financial Assistance/Sliding Fee Scale even if their income exceeds the guideline limit but is used for their principal care.
5. Prima Facia Write Offs: The hospital may choose to grant Financial Assistance/Sliding Fee Scale based solely on the initial determination. In such cases, the hospital will not complete full verification or documentation of any request.
6. Exceptions to this policy may be considered on a case by case basis.

Eligibility Determination

The hospital will make an initial determination of eligibility based on verbal or written application for Financial Assistance/Sliding Fee Scale. Pending final eligibility determination, the hospital will not initiate collection efforts or requests for deposits, provided the responsible party is cooperative with the hospital's efforts to reach a determination of sponsorship status, including return of applications and documentation within fourteen (14) days of receipt.

1. The hospital shall use an application process for determining initial interest in and qualification for Financial Assistance/Sliding Fee Scale. Should patients not choose to apply for Financial Assistance/Sliding Fee Scale, they shall not be considered for Financial Assistance/Sliding Fee Scale unless other circumstances or intent become known to the hospital.
2. Requests to provide Financial Assistance/Sliding Fee Scale will be accepted from sources such as a physician, community or religious groups, social services, financial services personnel, or the patient. If the hospital becomes aware of factors which might qualify the patient for Financial Assistance/Sliding Fee Scale under this policy, it shall advise him or her of the potential and make an initial determination that such account is to be treated as Financial Assistance/Sliding Fee Scale.

Final Determination

The hospital will exercise the following options in making the final determination for Financial Assistance/Sliding Fee Scale:

1. Financial Assistance/Sliding Fee Scale forms shall be furnished to patients when Financial Assistance/Sliding Fee Scale is requested, when indicated, or when financial screening indicates potential need. All applications whether initiated by the patient or the hospital should be accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for purposes of verifying income:
   - W2 withholding statements for all employment during the relevant time period.
   - Pay stubs from all employment during the twelve (12) months prior to the date of requests.
   - An income tax return from the most recently filed calendar year.
   - Forms approving or denying eligibility for Medicaid and/or state funded medical assistance.
   - Forms approving or denying unemployment compensation.
   - Written statements from employers or welfare agencies.

2. In the event that the responsible party is not able to provide any of the documentation

described above, the hospital shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person.

3. Patients will be asked to provide verification or eligibility for Medicaid or Medical Assistance. During the initial request period, the hospital may pursue other sources of funding, including Medicaid. If the hospital should have reason to believe information regarding the patients Medicaid eligibility is inaccurate, the hospital may refer the information to their contracted vendor Resource Corporation of America (RCA) for verification.
4. Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. The annualization process will be determined by the hospital and will take into consideration temporary increases and/or decreases of income.
    - The hospital shall provide final determination within fourteen (14) days of receipt of the application and documentation.

Denial

When an application for Financial Assistance/Sliding Fee Scale has been denied, the responsible party shall receive a written notice of the denial which includes:

1. The reason or reasons for the denial.
2. The date of the decision.
3. Instructions for appeal or reconsideration.

When the applicant does not provide requested information, and there is not enough information available for the hospital to determine eligibility, the denial notice will include:

1. A description of the information that was requested and not provided, including the date the information was requested.
2. A statement that eligibility cannot be established based on information available to the hospital.
3. Eligibility will be determined if, within 14 days from the date of the denial notice, the applicant provides all specified information previously requested but not provided.

The patient or guarantor may appeal the determination of non-eligibility for Financial Assistance/Sliding Fee Scale by providing additional verification of income or family size to the hospital within thirty (30) days of receipt of notification. The Director of Business Office and/or Chief Financial Officer will review all appeals. If this determination affirms the previous denial, written notification will be sent to the patient or guarantor.

If a patient has been found eligible for Financial Assistance/Sliding Fee Scale and continues receiving services for an extended period of time without completing a new application, the hospital shall re-evaluate the patient's eligibility for Financial Assistance/Sliding Fee Scale at least annually to confirm that the patient remains eligible. The hospital may require the responsible party to submit a new Financial Assistance application and documentation.

Documentation and Records

Confidentiality: All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form. Documents pertaining to Financial Assistance/Sliding Fee Scale shall be retained for six (6) years.

Referenced Documents

Reference Type	Title	Notes

Signed by (03/21/2007) Policy & Procedure Committee
(03/21/2007) Tom Litaker

Effective 03/21/2007 **Document Owner** Champion, Shelly

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http://www.lucidoc.com/cgi/doc-gw.pl/ref/svh_p:14600

SKAGIT VALLEY HOSPITAL
Sliding Payment Schedule
2008

Family Size	Less Than	More Than	But Less Than	More Than	But Less Than	More Than	But Less Than	More Than	But Less Than	More Than	But Less Than	More Than
1	**10,400**	10,400	13,832	13,832	17,264	17,264	20,800	20,800	31,200	31,200	41,600	41,600
2	**14,000**	14,000	18,620	18,620	23,240	23,240	28,000	28,000	42,000	42,000	56,000	56,000
3	**17,600**	17,600	23,408	23,408	29,216	29,216	35,200	35,200	52,800	52,800	70,400	70,400
4	**21,200**	21,200	28,196	28,196	35,192	35,192	42,400	42,400	63,600	63,600	84,800	84,800
5	**24,800**	24,800	32,984	32,984	41,168	41,168	49,600	49,600	74,400	74,400	99,200	99,200
6	**28,400**	28,400	37,772	37,772	47,144	47,144	56,800	56,800	85,200	85,200	113,600	113,600
7	**32,000**	32,000	42,560	42,560	53,120	53,120	64,000	64,000	96,000	96,000	128,000	128,000
8	**35,600**	35,600	47,348	47,348	59,096	59,096	71,200	71,200	106,800	106,800	142,400	142,400
9	**39,200**	39,200	52,136	52,136	65,072	65,072	78,400	78,400	117,600	117,600	156,800	156,800
10	**42,800**	42,800	56,924	56,924	71,048	71,048	85,600	85,600	128,400	128,400	171,200	171,200

Patient Responsibility	**0%**	**15%**	**30%**	**42%**	**55%**	**75%**	**100%**